SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

REQUEST FOR FINANCIAL INVESTIGATION

From: (Name and Address of DHHS)

Eligibility Worker: _____

Primary Individual's Name: (First, Middle, Last)

_____

Primary Individual's Address:

_____

_____

_____

To: (Name & Address of Financial Institution)

Household Number: _____

Social Security Number: _____

Account Number: _____

I AUTHORIZE ANY CUSTODIAN OF RECORDS AT THE FINANCIAL INSTITUTION NAMED ABOVE TO DISCLOSE TO THE SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) ANY RECORDS OR INFORMATION ABOUT MY FINANCIAL BUSINESS OR THAT OF THE PERSON(S) NAMED BELOW WHOM I LEGALLY REPRESENT OR WHOSE BENEFITS I MANAGE.

Name	Social Security Number
1	
2	
3	
4	

This request for information is made by the Department of Health and Human Services to determine my initial or continuing eligibility and the accuracy of benefits. I understand that any information obtained will be kept confidential and that:

1. My original signature as an applicant/beneficiary has been obtained in order for authorization to be valid.
2. The specific financial information that DHHS is requesting is checked below:
   - ☐ Account Number(s)
   - ☐ Type of Account(s)
   - ☐ Ownership of Account(s)
   - ☐ Present Balance
   - ☐ Account(s) closed within the last 60 months; Date and Closing Balance
   - ☐ Interest amount paid and date paid
   - ☐ Other Accounts (Christmas, CD, Stock, etc.)
3. I have the right to obtain a copy of the information released to the Department of Health and Human Services by the financial institution unless it was disclosed pursuant to a court order.
4. This authorization is not required as a condition of doing business with any financial institution.

SIGNATURE OF APPLICANT/BENEFICIARY: _____ **DATE:** _____

I CERTIFY THAT DHHS IS IN COMPLIANCE WITH THE APPLICABLE PROVISIONS OF TITLE XI OF PUBLIC LAW 95-630.

SIGNATURE (DHHS OFFICIAL): **DATE:** _____

PLEASE USE ATTACHED FORM FOR REPLY

For Use of Financial Institution

IF THERE ARE ADDITIONAL ACCOUNTS, PLEASE MAKE A COPY OF THIS PAGE AND COMPLETE.

Name: _____ **Social Security Number:** _____

Account A

Account Number:		Date Opened:	
Account Owner:		Opening Balance:	
Account Type:		Current Balance:	
Balance for the Month of: ☐ 1st Day of the Month ☐ Lowest Monthly Balance			
Balance for the Month of: ☐ 1st Day of the Month ☐ Lowest Monthly Balance			
Balance for the Month of: ☐ 1st Day of the Month ☐ Lowest Monthly Balance			
Balance for the Month of: ☐ 1st Day of the Month ☐ Lowest Monthly Balance			

Account B

Account Number:		Date Opened:	
Account Owner:		Opening Balance:	
Account Type:		Current Balance:	
Balance for the Month of: ☐ 1st Day of the Month ☐ Lowest Monthly Balance			
Balance for the Month of: ☐ 1st Day of the Month ☐ Lowest Monthly Balance			
Balance for the Month of: ☐ 1st Day of the Month ☐ Lowest Monthly Balance			
Balance for the Month of: ☐ 1st Day of the Month ☐ Lowest Monthly Balance			

IF ANY ACCOUNTS WERE CLOSED IN THE PAST FIVE YEARS COMPLETE THE FOLLOWING

Account Number	Owner(s)	Date Closed	Closing Balance

Name of Institution: _____ **Phone:** _____

Signature: _____ **Date:** _____

FINANCIAL INSTITUTION OFFICIAL